The Pickering Report Part V: a patient's bill of rights

By Edward Pickering

In CMAJ's fifth installment OMA commissioner Pickering explores public misconceptions about health care service, professional regulation and the role of the provincial medical association.

As its centennial project in 1967 the association established the Ontario Medical Foundation for research.

Funds available to the OMA and through it to the foundation are not limitless. If it is to maintain its voluntary membership its dues must be kept at a reasonable level and must represent value to members. But there may well be a need for re-ordering of research priorities. New programs may be seen to respond more immediately to present needs than existing programs which no longer have the same relevance.

In some cases, it may be possible for the OMA, having identified the need for a new program, to obtain additional funding for the foundation from other sources; the PSI Foundation comes to mind.

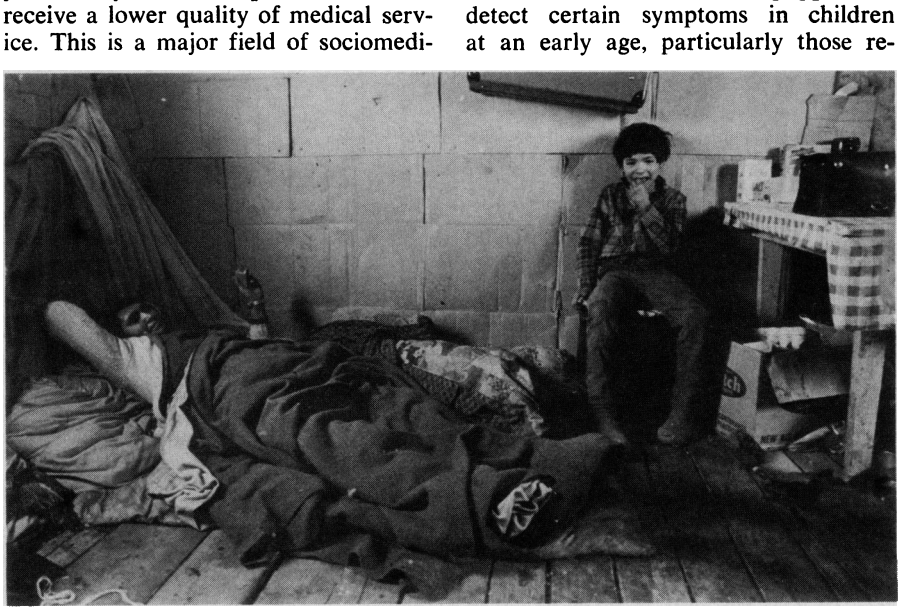
There were disquieting indications that low-income groups and areas and particularly the older persons involved receive a lower quality of medical service. This is a major field of sociomedical concern and should be made the subject of objective research.

To illustrate, the public hearing for this study received two important briefs about the unacceptably low level of available medical service in two low-income areas: Ward 7 in Toronto and Dalhousie Ward in Ottawa. If the facts stated in these submissions were supported by valid research, the results might be dramatic enough to ensure prompt corrective action.

93% of the persons involved in the public opinion survey felt that neighbourhood doctors should live and work directly with the poor in depressed areas. Thus, the public would appear to strongly share the view that low-income elements of the community are not being adequately served.

A highly significant matter for research and action, and one which would not involve too much in the way of resources, was presented at the public hearings and in other material submitted to the study.

On several occasions the hearings were told that the profession seems neither interested nor equipped to detect certain symptoms in children at an early age, particularly those re-



Public indicated poor and depressed receive lower quality medical care; doctors should live and work with socially deprived, commission was told.

lating to mental retardation, hearing handicaps and perceptual handicaps which result in learning disabilities.

These matters may be said to be outside the terms of reference of this study. They were, however, presented in such a way as to challenge the profession's willingness to face health care issues which affect large segments of the population but lie outside its traditional field of knowledge and concern. For this reason I feel it is proper to include the following observations.

A representative of the medical profession expressed the opinion that the detection of perceptual handicap, for example, was the responsibility of teachers rather than physicians.

Authorities in the field of perceptual handicap have emphasized that the earliest possible detection of symptoms increases the chance of improved learning in almost geometric progression and that these symptoms can be detected in some cases as early as one year of age. In other terms, the later the diagnosis the less likelihood the child will be an efficient learner and develop into a normal healthy citizen.

By the time children so affected reach school, they are often severely handicapped and sometimes irremediably so. Their inability to learn like other children at school, despite equal or greater intelligence, can lead to frustration, reduced feelings of self-worth, school dropout, delinquency and possibly crime.

A recent meeting of the Association for Children With Learning Disabilities in Toronto was told that one child in 10 suffers to some degree from perceptual handicap. Only a small percentage of children with such problems are recognized in time to help.

These related maladies are now included in the McMaster University curriculum and perhaps in others. But to wait years for a new generation of doctors to be trained to detect these ailments is not sufficient.

Repeatedly during the hearings, we heard the theme that doctors, through their professional organizations, should become more involved with emerging new issues affecting society in significant ways in our time. The area of perceptual handicap is one example. There is now a considerable body of literature available — for example, the *Journal of Learning Disabilities* — and I would like to suggest the OMA sponsor a research project (perhaps in conjunction with other disciplines such as psychologists) to determine the facts and produce a paper which will give doctors now practising the basic information they require.

With respect to hearing handicapped children I cannot do better than quote from the brief submitted by the Metro Toronto Association for Hearing Handicapped Children:

> We believe that it is the responsibility of the doctors to have all newborn children tested for deafness or hard-of-hearing in the newborn nursery before the child leaves the hospital, and if there is any question as to whether the child has a hearing loss then the parents should be advised as to the facilities available in Ontario to have an audiological assessment done on the child at the earliest possible age... Parent counselling must be made an integral part of the therapy provided to the hearing-impaired child. We do not expect the medical profession to provide this parent counselling but request that the doctors refer the new parents either to the Canadian Hearing Society or to the parents' associations in their region.

Action on this matter of crucial importance to many thousands of Ontario children, would seem to require little if any research but rather educational work with primary physicians and pediatricians.

No doubt, discussions in the community forums, recommended earlier, and in the advisory committee will produce from time to time other important subjects for research of this kind.

This kind of pragmatic research is not only socially desirable but will provide new vitality to the OMA as an association and to its public image.

Patients' bill of rights

Medical paternalism is increasingly being challenged by health consumerism. Patients are demanding a greater voice in their own health care and a greater recognition of their right to have their voice heard.

The public claims that adequate medical service is lacking in certain major respects. The profession does not deny that the public is entitled to high standards of medical care. Indeed, it probably feels that physicians are providing the best care that the degree of patient demand and the resources of the profession now permit. There is no inherent conflict between these points of view.

It may clear the air to define what the public is realistically entitled to expect in service from the medical profession and what in turn the profession recognizes the public is entitled to expect.

It is my belief that the time has come to issue a patients' bill of rights with respect to medical care and services.

There are two sides to the coin of writing and making a bill of rights widely known.

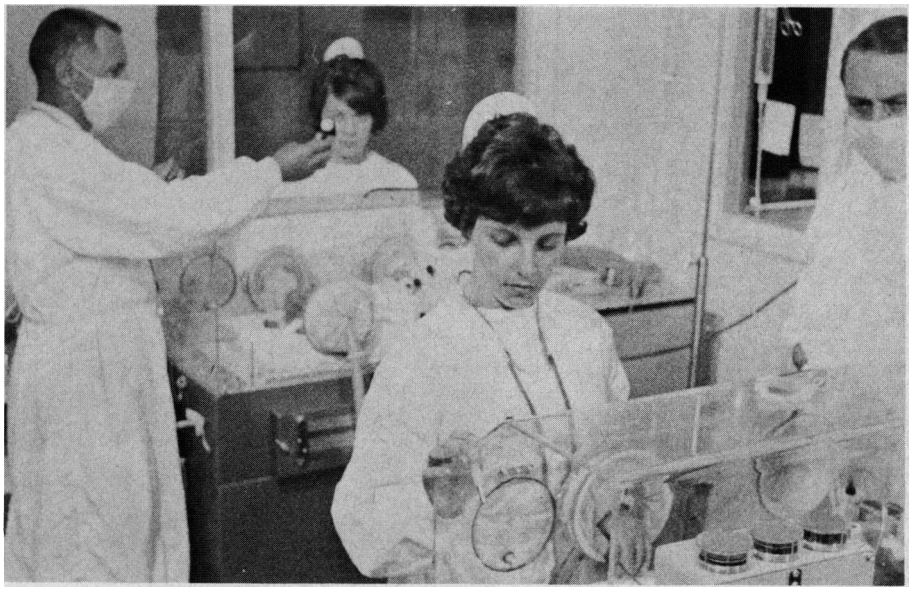
First, it may be that such a code will prove to be simply a crystallization of what most doctors already feel but have never set forth in so many words.

Second, such a document would represent the OMA's first statement of its official acceptance that the public does have clear rights in medical matters. This in turn would provide a standard against which doctors themselves as well as their patients could measure performance.

The publication, promotion and prominent display in doctors' offices and elsewhere of a bill of rights might well prove one of the most positive acts of communication which the OMA could undertake.

IT IS MY RECOMMENDATION THAT A PATIENT'S BILL OF RIGHTS FOR MEDICAL CARE AND SERVICES BE PREPARED IN CONSULTATION WITH THE ADVISORY COMMITTEE.

Purely as examples and as a basis



Newborns should be tested for deafness before they leave hospitals.

for discussion, some articles of a bill of rights might be:

- The right to equal attention regardless of economic status, sex, age, location and ethnic origin;
- The right of access to the service of a physician;
- The right to know what treatment (including medication) is being prescribed — why, the options, the effects and possible side effects;
- The right to a second medical opinion;
- The right to prompt response in emergency situations;
- The right to know what a physician is charging and how much services cost.

Public education, interchange

The hearings clearly showed that the public has little if any understanding of the organizations governing the medical profession in Ontario. They simply identify the profession with the Ontario Medical Association, to the virtual exclusion of the College of Physicians and Surgeons of Ontario, the Health Council, The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The OMA and the medical profession are synonymous in the eyes of the public. Consequently the OMA often falls heir to complaints and criticism where it has no responsibility.

There is, for example, little if any awareness of the fact that the OMA is a purely voluntary association of Ontario doctors; that it has no legal or statutory powers of any kind; that it cannot compel its members to do anything; and that it depends for its income upon the membership fees paid by its members.

Similarly, there is little understanding of the College of Physicians and Surgeons of Ontario; that it is a statutory body created under the Health Act of Ontario; that the law requires doctors to be members of the college; that it has responsibility for standards of medical education, for licensing doctors to practise in the province and for disciplining doctors for unethical behaviour; and, furthermore, that it has the necessary legal powers to carry out these responsibilities.

The Council of Faculties of Medicine is almost totally unknown to the general public, as is its role, in collaboration with the Ministry of Colleges and Universities, in determining the class size of the medical schools and hence the output of Ontario-trained doctors. Indeed there is the general misconception already noted that it is the medical profession (i.e. the OMA) which restricts the number of medical students in order to bring about high levels of earnings. There is little if any recognition that the rate of student enrolment (and hence of doctors graduating each year) is essentially in the hands of the provincial government which decides the amount of funds to be made available to the medical schools.

The need is clear for the association to identify for the public its own distinctive role, and inform them of its wide field of activities.

The public is almost totally unaware of the important work being done by the committees of the OMA. The following partial listing of these committees indicates the broad scope of its activities: child welfare, computers in medicine, health education, maternal welfare, misuse of drugs, paramedical personnel, public health and rehabilitation.

Contrary to widespread belief, this list demonstrates the OMA does direct itself to broad social issues with which the public is concerned. Over the years the association and its local academies have traditionally been identified with the struggle to bring about major reforms in the health field: the establishment of government departments of health; the pasteurization of milk; the campaign for pure water; inoculation against serious diseases; prepaid hospital and medical plans; and emergency ambulance services — to mention a few.

The OMA it seems has buried its light under a bushel. Its contributions to health care in Ontario have been substantial and deserve to be made better known to the public.

To illustrate the possibilities of simple yet effective programs, doctors' offices could be supplied with a pleasing display fixture for regular distribution of leaflets dealing with themes of interest to patients (e.g. "You and your doctor") and other matters of current medical information.

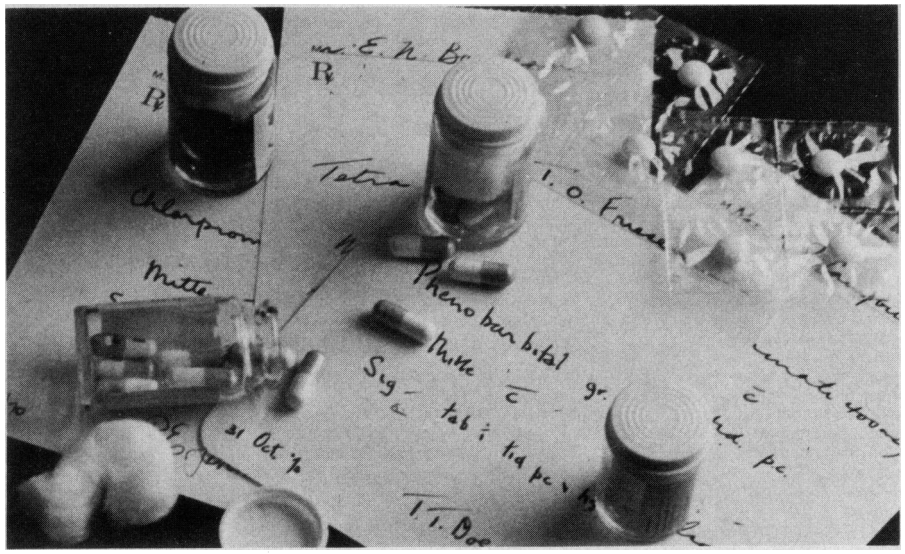
Code of billing ethics

For many decades the medical profession in Canada has made use of a system called the fee schedule. In its beginnings, this was a simple document printed on one side of a small card with suggested fees for a limited number of services. In billing patients, the doctor would take into account their ability to pay and his own competitive standing in the profession. He knew part of his billings would never be collected and often forgave part or all of his patients' debts. This system worked as a billing procedure because it was a highly personalized relationship between the doctor and the patients he not only served but knew so well.

As the practice of medicine became more complex, with more procedures and specialties, the schedule likewise grew in size and in complexity.

The introduction of insured prepaid medical plans instituted by the insurance industry or by the medical profession itself (i.e. Associated Medical Services, Windsor Medical and PSI) brought about a fundamental change. The fee schedule almost overnight became a formal basis by which the insurance carriers reimbursed the doctor for services he had performed. The doctor's personal knowledge of the patients' ability to pay was no longer a factor. The schedule of fees and the computer converted what had been a highly personalized billing system into a mechanical one.

During the period of the plans operated by the profession itself as well as those of public underwriters, there was some built-in protection to prevent abuse by doctor or by patient. The



The right to know what medication is being prescribed — why, the options, the effects and possible side effects.

professional plans were well administered and dealt strictly with suspected cases of abuse by doctor or patient.

When medicare took over, much of this vigilance went out the window. At the outset OHIP had few if any controls to detect abuse of billing. In any group in society there are always those who will not follow the rules of the game. Doctors are no exception. It is not, therefore, surprising that some doctors billed the plan for more services than they performed or performed more services for patients than were required. Eventually OHIP started catching up with billing abuses.

At the request of the Ontario Medical Association the medical review committee was set up in the College of Physicians and Surgeons to examine alleged abuses of this kind. The press has recently reported cases where the discipline committee of the college has imposed penalties in a number of cases. There can be no condemnation too severe for those doctors who have unethically billed the plan.

The college is to be commended for publishing the names of doctors found guilty of misconduct, together with a description of the charge and the penalty imposed.

The public is entitled to receive the same disclosure in cases of discipline within the profession as it does from the courts.

While it is the statutory responsibility of the college to investigate and discipline cases of this kind, the Ontario Medical Association has a moral responsibility to give guidance to its members. Indeed the fee schedule contains a statement of the principles of ethical billing. While helpful, the emphasis of this is mainly on procedures and billing ethics in terms of accepted practices within the profession.

In view of the serious charge of alleged overbilling by some doctors and the unfortunate effect of the transgressions of a few physicians on the good name of doctors generally, it would seem appropriate for the association to update this statement in the light of current problems and severe criticism in the news media and the legislature.

The OMA obviously does not condone billing abuses by its members. It is gratifying to observe that the president of the association in a recent public statement strongly condemned those doctors who have brought discredit upon the profession as a whole. In today's climate, it would be a socially useful step for the OMA to expand its present statement and unequivocally define and spell out in detail its attitude on this fundamental matter of ethical behaviour.

The association should make this code available not only to its members but to patients generally throughout the province.

I RECOMMEND THAT THE OMA REVISE ITS CODE OF BILLING ETHICS.

Inform patients of OHIP payments

At the outset, medicare was misconceived by the public as making free medical service available to all under all conditions at any hour of the day or night. No educational campaign had been carried out to remind patients that the service is not being provided "free", but comes out of their own pockets in the form of government-collected premiums and taxation. No attempt was made to caution the general public to exercise some discretion in the manner and the times at which they demanded medical service.

In the public opinion surveys, 82.7% of the participants expressed the view that too many people go to doctors who don't need to.

A group of hospital administrators related, as perhaps an extreme example, how one patient made 28 visits in one year to the emergency department of one hospital and over 50 to another; abuse of this kind is frequently observed.

OHIP has developed profiles of doctors' billings. It should also develop profiles of patient use of services to identify those who may be exploiting the system. This cannot be done until the OHIP computers record the names and addresses of patients and assemble particulars about their demands for medical service and resulting costs.

The billing system employed by OHIP does not provide the patient with any information as to the number and the cost of the services which the doctor claims to have performed. In the case of participating physicians, the doctor sends an account to OHIP and is reimbursed directly by it. The patient receives no document or information of any kind. This is an open-ended invitation to abuse.

It is incredible that people who receive the benefits of a state-controlled plan paid through direct and indirect taxation of over $500,000,000 a year, are not acquainted with the nature and cost of the services provided for them.

The province of Manitoba, for example, submits to each patient a statement (clearly identified as not a bill for payment) providing details of date, doctor, nature of service and amount paid by the government on that taxpayer's behalf. In Quebec, the patient is furnished with a copy of a billing statement showing the service and fee upon leaving the doctor's office and a copy is also sent to the provincial government.

Devices of this kind act as a two-edged sword. They tell members of the general public who are overusing the system that this is all a matter of record and remind others of the cost of their medical treatment. It likewise provides a built-in check for the doctor who is tempted to overbill.

It is time that Ontario patients also be brought into the billing process.

I RECOMMEND THAT THE OMA URGE THE GOVERNMENT OF ONTARIO TO DEVISE SOME PRACTICABLE MEANS OF INFORMING THE PATIENT OF HIS OHIP BILLINGS.

Joint committee on compensation

Dealing with the fourth of the terms of reference, how best can revisions in the fee schedule be made from time to time without confrontation and conflict?

The practice has been for the OMA to revise the schedule every two years. The last revision took place on May 1, 1971. The next would normally have occurred May 1, 1973. This was voluntarily deferred by the association until May 1, 1974 to enable this study to be completed.

So far as we can ascertain, there is no other example of a profession, a union or a commercial enterprise voluntarily freezing the basis of its wage or pricing structure, especially for a three-year period. The association is to be commended for this unusual act taken in a period of rapidly rising costs of doing business, including the costs of practising medicine.

Since the revenues for paying for doctors' services now come mainly from government sources, we face a fundamentally altered situation. In the days when the doctor determined the amount he would bill, and the patient paid him in full or in part according to his situation, it was only natural for the fees to be developed by the profession itself.

The advent of medicare introduced an entirely different dimension to the physician-patient relationship. The doctor, generally speaking, is reimbursed for services not by the patient but by the state, creating what the medical economists describe as a "bi-lateral monopoly". This rather dramatic shift in the responsibilities for physicians' fees carried with it the implication that government cannot ignore its ultimate responsibility to the taxpayer.

This was reflected in the observations at the public hearings where organizations ranging from labour and farm movements to chambers of commerce, medical schools and individual doctors as well, suggested the time had come for some public presence in this

matter. It seems self-evident that the Ontario Medical Association should, as a matter of public responsibility, espouse the principle that in this field they are now partners in making decisions that were formerly their own exclusive prerogative.

Various methods for determining the fee schedule were presented at the hearings. Common to all of these was the underlying opinion that the association should no longer exclusively control its own fee structure.

Methods for setting the fee structure can cover the full range of procedures now practised in varying degree in other sectors of the community. These extend on the one extreme from the system of outright confrontation under which physicians could withdraw their services should agreement not be reached with government, to the other extreme of compulsory arbitration which would bind both the profession and government to a fee schedule established by independent outsiders.

A form of tripartite negotiation was proposed in the hearings, with the public's having equal representation as a separate party in a negotiation procedure between the OMA and government. Additionally, the Ontario Hospital Association and one of the universities submitted that their communities should be represented in some capacity because of their special relationship to the medical profession.

An adversary system based upon the possible withdrawal of physicians' services is completely contrary to the public interest. Continuity of medical services must be assured if patient welfare, which unquestionably ranks as one of our highest social priorities, is to be protected. Furthermore, confrontation and withdrawal of services are alien to the traditions of the medical profession; and it was precisely to avoid them that the present study was established.

Neither is compulsory arbitration a satisfactory alternative. On the surface, it appears to provide a pat answer to resolving the difficulties of effecting settlement of the fee schedule while at the same time maintaining the services of physicians. But it is not realistic to expect government to delegate its final responsibility for so major an expenditure as the cost of medical care to outsiders who are not accountable to the tax-paying electorate.

It is true that universities and hospitals have a special relationship to the medical profession. They are both involved in the education of physicians and in research. It would seem to follow, perhaps in differing degrees, that each of them could fairly claim the right to some voice in the matter of physicians' incomes. On the other hand, in large measure they already exercise some influence having, as they do, the authority to determine compensation for those physicians engaged by them.

More importantly, experience suggests that modification of traditional and long-established practices can be accomplished most effectively if the proposed change seems reasonably acceptable to those most immediately involved and, further, that the change does not introduce too many new elements which may prevent the new process from working effectively. Evolutionary change is better than drastic sudden change. The opportunity for success would appear greater if changes to the existing system of modifying the fee schedule were confined to those which are essential to satisfy the public interest.

Exclusion of the universities and hospitals from participating directly in the process would not deprive them of having an effective voice in the matter. Through their existing channels of communication with both the government and the OMA, these organizations should have adequate outlets for their important points of view.

IT IS WITH THESE CONSIDERATIONS IN MIND THAT I AM RECOMMENDING THAT THE OMA EXPLORE WITH THE GOVERNMENT OF ONTARIO THE ESTABLISHMENT OF A JOINT COMMITTEE ON DOCTORS' COMPENSATION.

The committee comprising three representatives each of the association and government would be responsible for reviewing and revising the fee schedule. It would not function spasmodically but in a continuing process with both short-term and long-term objectives, as enlarged upon later.

To bring as much objectivity as possible to bear on the joint committee on doctors' compensation activities, its chairman should be a distinguished Canadian recognized for his competence, impartiality and devotion to the public interest. The chairman's status would be greatly enhanced if his appointment resulted from mutual agreement.

Should this, at any time, not prove possible, a formula should be established to effect the chairman's appointment on as neutral and objective a basis as feasible. As a possibility, a committee composed of independent reputable citizens, such as the Chief Justice of the High Court of Ontario, as chairman, the president of the Council of Ontario Universities, the president of the Ontario Federation of Agriculture, the president of the Ontario Federation of Labour and the president of the Ontario Chamber of Commerce, could prepare a panel of

names for consideration by the joint committee for doctors' compensation.

Such a committee would be empowered to appoint the chairman should the members of the joint committee for doctors' compensation be unable to reach agreement on the selection from the panel recommended.

The concept contemplates that in those situations where matters of exceptional difficulty arise, and where consensus proves impossible to achieve, the chairman would have the authority to retain independent counsel and such other technical assistance as might be necessary to enable him to reach informed, independent conclusions. It is not intended, however, that he should have decision-making authority, unless in any particular instance the committee's members unanimously agree — otherwise, a compulsory form of arbitration would result.

The success of such a concept is dependent upon the good faith of the parties, both recognizing that they are concerned with providing a service essential to the well-being of the citizens of the province.

The chairman's objective leadership can be of paramount importance in seeking reasonable solutions by consensus.

As I envisage the procedure, the fee schedule would be under continuous study by a small secretariat under the direction of the joint committee on doctors' compensation comprised not of physicians but of a medical economist and research statisticians. Research information being independently generated by the OMA and OHIP would also be provided to the committee. Conversely, research generated by the committee should be available to the Ontario Medical Association and to the Ministry of Health.

Broadly speaking the research conducted on behalf of the joint committee on doctors' compensation should be directed at relating the fee to the worth and value of the services performed.

Now is the time . . .

The time has come for a major reassessment of the fee schedule in several respects. Doctors themselves recognize this. Almost a third of those responding to the physicians survey felt the schedule was poorly organized.

The schedule contains ambiguities which make it possible for the individual doctor to improve his income by sophisticated billing. The schedule should be an effective instrument for minimizing the range of billing interpretations while ensuring that doctors are adequately paid for services rendered.

Many organizations and individuals have suggested that technological advances and other developments in modern medicine have made some parts of the schedule anachronistic. The favourite illustration is the payment of a fee for chronic dialysis which, when originally introduced, required several hours of physician's personal time in performing the process. Today it is largely the work of technicians. Other examples have been suggested as warranting investigation: for example, certain procedures in laboratory medicine, in electrocardiography, endocrinology and metabolism, ophthalmology and others.

We also heard a great deal about inequities in the schedule as between various specialties. Most frequently mentioned were the relatively low values attached to services in psychiatry, internal medicine and rehabilitation medicine.

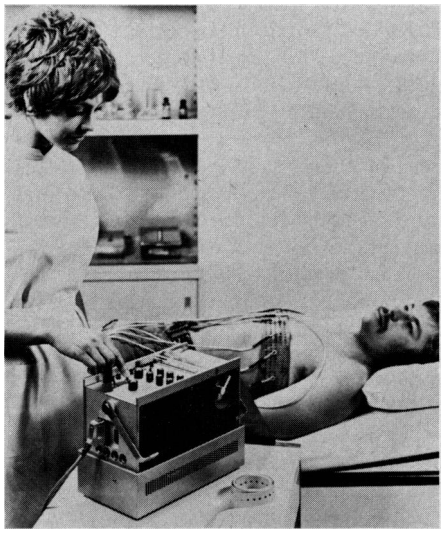
The adequacy of the fee for a house-call was also questioned frequently and should be re-examined.

The short-term and long-term processes for modification of the fee schedule will be quite different. The matters mentioned above would belong to the short-term.

The joint committee on doctors' compensation could well take the foregoing matters as their initial agenda.

The long-term approach should include a scientific evaluation of services in terms of relevant criteria to be established.

The joint committee would initially concern itself with the amount of fee payment for specific procedures and with the other short-term matters outlined above. But, looking to the future, the fee schedule should evolve from a mechanism for the payment of doctors' services into an instrument for influencing the manner, place and time medical services are provided in the community interest.



Technological advances have placed many procedures in the hands of technicians.

Progressively, the scope of the joint committee could and should extend to broader considerations, such as the overall cost of doctors' services and methods by which they can be made more productive in terms of the quality of medical care and the health needs of the province.

The joint committee also could concern itself as changing conditions require with developing new methods of compensation — perhaps involving existing and new elements — which would be constructive both in terms of emerging forms of medical practice and of offering the profession a wide choice of acceptable forms of compensation.

As envisaged in this report, the short-term activities of the joint committee would be to seek agreement on the amount of fees for individual procedures, in effect identifying the OHIP schedule of benefits with the fees paid to participating physicians under the OMA's schedule.

It would, however, be essential to work out some arrangement by which the non-participating physicians could legally and ethically bill their patients directly for a larger amount, provided the safeguards referred to later in this report are meticulously met, i.e. the patient having the choice and opportunity of electing to use a non-participating physician if so desired and, in this event, of being informed in advance of any additional payment required.

In the absence of such a procedure, the recommendations of this section of the report could have the unintended result of making difficult if not impossible the part played by the non-participating physician in the medical services of Ontario.

Nothing here suggests that the OMA tariff committee should cease to work on amendments to the schedule. On the contrary, they should intensify their examination so that the association's representatives on the joint committee on doctors' compensation would have carefully considered proposals to submit. In taking the initiative for a major revision of the character and design of the schedule, the OMA will be rendering the system — doctors, patients and government — an important service.

Some members of the profession will unquestionably view the recommendation of a joint committee on doctors' compensation as a radical change. There is no denying it. However, any unilateral system of fee setting under present conditions is anachronistic and is no longer socially or politically defensible.■